Dr. James E. Hollingsworth
• Chiropractic Physician
• Diplomate American Academy of Pain Management
• Clinical Member American Psychotherapy and Medical Hypnosis Association

HIPAA Privacy Form
Please answer all questions completely

Patient Acknowledgement Regarding Notice of Privacy Practices for
Hollingsworth Chiropractic

I have had the opportunity to review the Notice of Privacy Practices at Hollingsworth Family Chiropractic and, if requested, have been supplied with a copy of these practices.

Patient Name (print name): _____ Date: _____

Patient Signature: _____

Parent/Guardian Signature: _____
(if applicable)

The HIPAA Privacy rule gives individuals the right to request confidential communications or that a communication of private health information be made by alternative means, such as sending correspondence to the individual's office, instead of the individual's home.

I wish to be contacted in the following manner:

Home Phone (check one):
- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with call-back number only

Work Phone (check one):
- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with call-back number only

Cell Phone (check one if applicable):
- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with call-back number only

Written Communication (check all that apply):
- ☐ Okay to mail my home address
- ☐ Okay to mail my work/office address
- ☐ Okay to fax to this number: _____

E-mail Communication:
- ☐ Okay to e-mail this address:_____

Patient Signature: _____ DOB: _____ Date: _____

Parent/Guardian Signature: _____
(if applicable)